Philosophy in Psychiatric Practice

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Chapter 2: The Qualitative Study: aims and methods

2.1 Aims of the study

The main aim of the qualitative study was to explore the nature and the action of philosophical assumptions in the practice of psychiatrists. We were interested in three main areas: diagnosis and classification, science and legitimacy, and mental disorder, and in examining their role in practice. The choice for these areas is based on the fact that they cover a wide area of practice and of the philosophy and psychiatry literature (cf. Fulford et al. 2006, Fulford et al. 2013). Our primary aim was to identify and describe the philosophical assumptions. Our secondary aim was to explore their role and action in practice, in other words: their impact. Though the focus of the study was on the psychiatrists, no assumptions were made as to whether philosophical assumptions function as cognitive representations, whether they are interactional constructions, or institutionally embedded within working procedures. The available literature points to "all of the above". The choice for qualitative methodology was made from a desire to approach the subject from a naturalistic point of view, and from the aim to make an effort to bridge the aforementioned 'communication gap' by conducting 'philosophical field work', hopefully productive for both philosophy and psychiatry.

2.2 Design

For this study a naturalistic inquiry approach was used (Lincoln & Guba 1985, Beuving, & de Vries 2015). Naturalistic inquiry is characterized by research in natural settings, qualitative methods, purposive sampling, inductive analysis, a grounded theory approach, a case study reporting mode, the tentative application of findings, and special criteria of trustworthiness (Lincoln & Guba, 1985). The investigator studies real-world situations as they unfold naturally. Further, the researcher recognizes the existence of multiple constructed realities. The naturalistic case study approach aims to examine local, contextually bound

relationships from a perspective which combines dialogical engagement with 'multiple partiality', requiring the interviewer to engage the subject from multiple particular standpoints (Abma & Stake 2014). The method of naturalistic inquiry was chosen because of its relative flexibility as to the characteristics of the domain under examination. As was apparent from Chapter 1, the specific subject of philosophy as it manifests in psychiatric practice has very rarely been examined. Even Barrett's (1996) naturalistic approach does not focus primarily on philosophy. Therefore the nature of the ways in which philosophy manifests in practice was still to be determined. The flexibility of naturalistic inquiry allows for tracking of such manifestations. On the other hand, practical considerations of time and money required choices with respect to the scope of the study. One important choice was to either follow an embedded naturalistic approach such as Barrett's study, offering an in-depth view of a specific locale, or a less comprehensive, but broader reach involving multiple settings. As an important objective of the study was to achieve an impression of the varieties and differences of philosophies (cf. Fulford & Colombo 2004) across locales and between individual psychiatrists, we opted for the broader, less immersive, approach. Also, this is an explorative study, not aiming to evaluate certain policies or forms of practice. Where normative issues are addressed in this study, this is as consequence of the description and analysis of various practices.

A general feature and subject of debate in qualitative studies is the tension between emic and etic perspectives (Lett 1990). An 'emic' approach (also referred to as 'insider' or 'bottom-up') takes as its starting point the perspectives and words of the participants, whereas etic approaches start from concepts, perspectives and theories outside of the setting being studied. The 'etic' contribution to this study was purposely limited to the previously mentioned three organizational sectors, three main themes of philosophical interest, and, based on literature study, discussion in the research group and an initial pilot, an initial framework related to the three philosophical themes (see below under framework analysis). In qualitative methodology, one way of addressing the emic/etic tension is by ensuring the theory pertaining to the phenomena under study develops from continuous interplay between data collection, data analysis and literature review throughout the research process. The findings of the study progress as a series of interim conceptual frameworks and explanations of the data. More details are provided in the section on the framework analysis. A central idea in this study is the notion that the language used in practice is a clue to philosophical beliefs in play. This does not imply an unambiguous transparency of meaning, and the methodology was adapted to this fact. Therefore, in coding, text sequences were initially coded as 'locations of philosophical beliefs', with memos attached offering

ideas as to possible content. The content was subsequently derived from the interview, from multiple coding and triangulation, and respondent validation at multiple steps in the process.

Another limitation of this study is that in the interviews and notes it focuses one-sidedly on the psychiatrists. Initially, the research group was interested in characterizing 'the philosophies of psychiatrists'. This was part of the aim to construct a three-part series of studies, one focusing on psychiatrists, one on patients, and the final one on the interactions between the two. However, it became increasingly apparent that the dialogical nature of practice precludes definite statements as to ownership of the narrative of practice. Individual notes of the psychiatrist, in the sense that they serve a communicative function, proved to be adaptive to certain goals, and constrained by institutional limits. The question of ownership of philosophical ideas for this study was not central to the aims of this study as opposed to their manifestation in practice. Therefore, this study does not pretend to offer a full account of 'the' philosophy of psychiatric practice, but to provide a perspective, weighted from the point of view of psychiatrists.

A further constraint is the use of audio recordings rather than video, or the embedded presence of a researcher. In part, this was a choice based on the above preference for scope. The choice for audio recording was based on the desire to record in as unobtrusive manner as possible. Having visual information unavailable limits the access to nonverbal cues in practical interaction. To a degree, the structure of the study, including questionnaire, session notes and reports, and the interview directed at discussing the intake, allows for possible capture of such phenomena, though these rely on respondent initiative.

The research group consisted of one psychiatrist and philosopher with training in qualitative research methods (the primary researcher, AR), two residents of psychiatry (JL and EP) one of whom is also a philosopher, and a professor of psychiatry and philosophy (GG). The interviews were all conducted by AR.

As an aid to ensuring methodological rigor, the COREQ checklist was applied (Tong, Sainsbury and Craig 2007). The COREQ checklist (Tong 2007) for interviews as applied to this study is included in the appendix. All research investigators have participant experience in the practice of psychiatry, as during the study they were either qualified psychiatrists or residents in psychiatry. AR (male) has been in full-time practice as a psychiatrist since 2001. His professional experience involves adult clinical and ambulatory care, including a broad range of psychiatric, psychotherapeutic, and emergency psychiatry. His philosophical basis was established by following an MA in Philosophy and Ethics of Mental Health at Warwick University. JL (female) and EP (male) both participated in parts of the study, performing independent coding, joining in the research team discussions

and compiling individual case reports. At the time of their involvement with the study, they had 2-5 years' experience as residents in psychiatry, on rotation at different departments, both clinical and ambulatory. JL has a B.Sc. in philosophy. GG (male)is a philosopher and psychiatrist with more than 30 years of clinical experience. He is head of residency training. His clinical experience is chiefly involved with anxiety, mood, personality, developmental and eating disorders and combinations of them. None of the research team had any concurrent therapeutic relationships with the patients involved in the research project. Professional relationships with participants were limited by sampling for participants working in departments and institutions other than the RT. At various points preceding and throughout the study advice was sought from experienced qualitative researchers. The research interest of the primary researcher is explained in Chapter 1, which also includes basic assumptions related to this study, chief of which is the notion that philosophical assumptions can be elucidated in a valid manner through an empirical approach. Permission for the study was granted by the Medical Ethical Committee of Noord-Holland, the Netherlands.

Participants were recruited through theoretical, convenience, and purposive sampling (Crabtree & Miller 1999, Silverman 2000). Three sectors of psychiatric practice were chosen by the research group (private practice, academic practice, and institutional practice), after review of the historical literature (Oosterhuis & Gijswijt-Hofstra 2008) showed these areas to be fields within psychiatry with specific organizational characteristics and goals, whilst providing a substantial degree of representation of the breadth of the area psychiatrists work in. A conscious decision was made to recruit a number of psychiatrists from one (institutional) department to enable a focus on individual differences in one setting, whilst varying contextual settings (urban or rural) and recruiting psychiatrists with self-declared (e.g. through their websites) explicit affiliations with a psychotherapeutic or other treatment approach, including explicitly stated religious and/or spiritual affiliation. Participants were recruited by either approaching departments for ambulatory care (institutional and academic) or by approaching individual practitioners (private). Most initial requests were made by e-mail, subsequently information on the project was supplied by a standardized description of the aims of the project (see appendix). In some cases, the request for participation was relayed to potential participants though a department head, therefore a precise number of refusals to participate cannot be supplied. An estimation thereof is that approximately 20% of those approached agreed to participate. From the initial participants there were four drop-outs: two due to change of position during the data collection process, and two due to scheduling problems. For most refusals, the time investment in the study was given as the

reason for denying the request. This fact may produce a form of bias in the sample, in the sense that the psychiatrists participating are sufficiently free in their schedule to be able to participate. Psychiatrists who feel strongly pressured by busy practice may be underrepresented in this study, which is a relevant factor since decision making under time pressure proceeds differently than otherwise. A recommendation of this study is to apply this format to studying practice in more pressured circumstances such as emergency psychiatry. Specific details of sampling relating to the main themes of the study can be found in chapters 3,6 and 8. Participants were interviewed at the setting of their professional activity, either in their work office, or, in the case of privately practicing psychiatrist, in their private office. In the latter case this sometimes involved visiting participants in their own home, since some private practitioners practice from a home office. If possible interviews were timed outside of working hours to ensure as few interruptions as possible and to allow participants time and space for reflection. This was possible for 80% of the interviews. No-one was present except for the interviewer and the interviewee.

A total of 30 psychiatrists, 10 from each sector (academic, private, and institutional), participated in the study. Average age of participants was 52, (sd. 9). Averages per locale were: institutional 49 (sd.10), academic 53 (sd.7) and self-employed 55 (sd.9). 7 Females and 23 Males participated, implying the sample is skewed towards male participants. Average years of experience as a psychiatrist was 17.3 years (sd 9.7), per locale: institutional 14.1 (sd.7.6), academic 19.3 (sd.7.6) and self-employed 18.7 (sd.9.3). Practical limitations prevented extension of the study into alternative demographic groups of interest. Besides a fuller representation of female practitioners, especially younger and less experienced practitioners would be of significant interest, especially given changes in emphasis in training throughout recent decades (e.g. the rise in influence of evidence-based medicine and the rising prominence of competence-based training (Frank & Danoff 2007)). The demographics of the selected group limit the representative generalizability of this study.

Sensitizing concepts (Bowen 2006, Blumer 1954) for the study were selected, based on examination of the literature in philosophy and psychiatry. Firstly a division in three main themes: Diagnosis and Explanation, Science, and the Concept of Mental Disorder. These main themes were chosen due to the research group's assessment that these themes represent areas in which philosophical and practical issues interact in a potentially contentious manner, and because the themes represent a substantial part of the literature in the field. Secondly two general theoretical notions, namely Jaspers' (1959) well-known distinction between causal

and meaningful connections between phenomena, and Engel's (1977) biopsychosocial model. These were selected, again from the judgment that these were high-level, ubiquitous conceptual themes encompassing a large area of the philosophical-psychiatric field. The initial thematic framework was developed with the help of these concepts (see below).

2.3 Data collection

Three methods of data collection were applied: a) audio recording and transcription of initial intakes and related practitioners' reports; b) a self-report questionnaire aimed at elucidating explanatory models and c) semi-structured interviews focusing on personal experiences, ideas and opinions. Following an iterative approach, data collection took place through a series of 4 steps.

The first step consisted of acquiring audio recordings of initial encounters of psychiatrists with patients. All such encounters were within the ambulatory setting. The researchers were not present during the encounter in order to ensure as natural a process as possible. Informed consent was obtained from all participants, both psychiatrists and patients. An unobtrusive audio recorder was used to record the full formal 'intake', the generally recognized initial encounter or series of encounters wherein the psychiatrist is expected to perform his initial diagnostic work, come to a diagnosis and classification, and draw up a treatment plan with the patient. This particular phase of the professional encounter was chosen by the research group due to a) one main theme being the exploration of the process of exploration and diagnosis and b) the expectation that this phase of treatment would be a fertile area for examining philosophical assumptions. The audio recording was transcribed verbatim. Also, anonymized medical reports of these meetings written by the participants (either for individual professional use or formal reports to referring physicians) were obtained and transcribed.

The second step was the completion by participants of a Dutch translation of the Maudsley Attitudes Questionnaire (MAQ, Harland et al. 2009), a questionnaire aimed at examining psychiatrists' concepts of mental illness. This questionnaire was chosen by the research group as an aid to characterizing participants' philosophical views. The advantages of the MAQ lay in the fact that it encompassed the three main areas of study, and added a further differentiation across different (DSM-) diagnoses, offering a succinct impression of participants' views. The MAQ was not treated as a psychometric instrument, as it had not been validated as such, but as a further source of information on participants' attitudes (see data analysis). Individual results on the MAQ were discussed within the research group in the

second step of the study, and related to the materials collected in step 1. Notable findings, emerging themes, and discrepancies between the materials were detected through constant comparison, and these were added as subjects and questions to the semi-structured interview, in which discussion of the results of the MAQ was one section. An overview of results of the MAQ can be found at the end of this chapter.

The third step had three interlocking, aims: discussing the intake and the written report, discussing the MAQ, and performing iterative member checks for the developing frameworks. It consisted of a semi-structured interview performed by the primary researcher (AR). The interview scheme was compiled by two members of the research group (AR and GG) prior to the study, based on the initial literature study, the three main themes and the sensitizing concepts. The interview scheme and topic list is shown in fig. 1. The main structure of the interview was for the participant to describe his or her professional development and then to address the nature and degree of representativeness of the recorded intake: to what degree were the presenting problems of the case and the practitioner's responses representative of the latter's general practice? Subsequently the more theme-related questions were posed, with a focus on grounding the answers in practice as much as possible. As can be seen, most questions are open-ended. The interview strategy chosen was in-depth analysis where the interviewer strove for clarification, elaboration and motivation using 'probes' described by Rubin & Rubin (2012, Chapt 9), and to relate conceptual and philosophical ideas to practice as much as possible. Because questions related to the first two steps of the study were integrated into the interview, this step also served as part of the respondent validation. By his profession, the interviewer was familiar with professional psychiatric terminology. This also constituted a risk of premature interpretation of respondents' answers. This worry was addressed through summaries and repeated respondent validation both within and following the interviews. Within the interviews, care was taken to follow quality safeguards described by Kvale (1996), Britten (1995) and Miller and Crabtree (1999). Where logical inconsistencies were noted, they were challenged (examples are provided in transcripts of interviews in Chapters 3, 6 and 8). All previously collected materials were used as sources for the interview. Interviews consisted of a maximum of two meetings, each on average one to one and a half hours long. Field notes were made during the interview. During research group meetings the topic list was critically assessed. This led to a number of adaptations in the interview structure, e.g. allowing the subject to being with a general personal/professional introduction before advancing to theme-related questions.

Semistructured Interview

I. Introduction
Ask the participant to describe their professional development starting from medical training through to current employment.

II. Intake
A General
1. To what degree was this intake representative of your practice method?
2. Does your manner of practice accord with your professional ideal?
3. If not, what makes it less than ideal? What causes this?
4. Is your manner of questioning influenced by the framing of the interview? How?

B Specific
Discuss findings from review of intake and written reports related to three main themes.

III. Theme-specific questions
Diagnosis and Classification
1. What are your views on the best manner in which to perform diagnosis?
2. What are your views on classification?
3. How do diagnosis and classification relate to each other?

Science & Legitimacy
1. What is your approach to using science in your practice? To what degree is your practice scientific?
2. What are your general views on psychiatric science?
3. What are your general views on the causes of mental illness?
4. Do you follow any theoretical schools of thought on the above?
5. What/who has influenced your views?
6. What are your views on professional legitimacy and responsibility?
7. What general values guide you in your practice?
8. Where do these values derive from?

Mental disorder
1. What are your general views on the nature of mental illness?
2. What is your concept of inclusion/exclusion into the category of mental disorder?
2. Are mental disorders naturally occurring phenomena, existing independently of man?
3. What does the term 'brain disease' mean? Which diseases are brain diseases? Which aren't? Why?
4. Can you describe, in general terms, your view of the relationship between mind and body?

IV. MAQ
Discuss the results of the MAQ with the participant.

Fig 2.1. Schema of Semi-structured Interview

The fourth and final step consisted of the compilation of a final case report of each participating psychiatrist (Abma & Stake 2014), characterizing the views of

participants within the main areas of the study, and requesting comments and corrections as respondent validation.

2.4 Data analysis

The qualitative methodological approach taken in this study was that of framework analysis, a method recently gaining popularity in health-related research (Lacey & Luff 2009). Framework analysis involves a five-stage process of analysis (Pope, Ziebland & Mays 2000): a) Familiarizing; b) Identifying a thematic framework; c) Indexing; d) Charting; and e) Mapping and Interpretation. Although the process is described in a sequential order, and certain stages logically precede others, the analysis may involve both jumping ahead and returning to previous steps to rework previous ideas, based on observed connections. The strength of the framework approach is that by following a well-defined procedure, it is possible to reconsider and rework ideas in a transparent manner precisely because the analytical process has been documented and is therefore accessible. This was considered to be crucial for this study where the nature of the phenomena under investigation (philosophical ideas) may not be immediately apparent. The risk of observer bias is met through recognized methods for ensuring rigor in qualitative research, but is amplified by applying an analytical method which provides a high degree of transparency as to the development of concepts and frameworks from the material.

Familiarizing

At this stage the researcher immerses himself in the material by listening to audio recordings, reading the transcripts thoroughly. This was done by the principal researcher for all transcripts, and by JL & EP for the transcripts they coded. In this study, all researchers were themselves psychiatrists, which affords advantages and disadvantages: psychiatrists are already quite familiar with the content of the field itself and the parlance involved. Conversely, the researchers' own (philosophical) ideas and values with respect to psychiatry may affect their interpretations of the phenomena.

Identifying a Thematic Framework

In this stage, the analyst takes note of recurrent themes, the range of responses, and emerging issues, and uses these to draw up a thematic framework with which the material can be examined and sorted. This framework must be in part related to the research question, and in part to the responses and themes observed. The initial framework is often largely descriptive and heavily rooted in a priori issues. It is then applied to a few transcripts whilst categories are refined to become more

responsive to emergent and analytical themes. In this study, the initial framework was drawn up based in part on the findings of the first five participants, and in part on the sensitizing concepts drawn from the philosophy of psychiatry literature mentioned previously.

Indexing

This refers to the process whereby the thematic framework is systematically applied to the data in its textual form. All data are read and annotated according to codes derived from the initial thematic framework. Coding and annotation was performed using Atlas.ti coding software. Data collection and coding was performed for all participants by the principal researcher (AR), whilst EP and JL performed independent coding on 10% and 33% of the participants, respectively. Codings were subsequently discussed until consensus was reached.

Charting

At this step, the researcher moves from the coding of the individual transcripts to establishing a picture of the data as a whole. The data are extracted from the transcripts and placed within the developing thematic framework under the appropriate heading. To this end charts are drawn up of each general thematic area, wherein the data from individual cases are entered. Charting involves abstraction and synthesis. Each piece of coded text is studied and a derived summary of the data is entered on the chart. This may be done at different levels of abstraction, from verbatim citations to an emergent theme, as long as the data entered are traceable to the transcripts themselves. The original text is referenced so that the source can be traced and the process of abstraction can be examined and replicated.

For this study, charts were compiled for each of the three main themes, for the data sources of the clinical intake, the written reports, and the semi structured interview The structure of the charts was derived from research group discussion of the material as a whole in relation to the main themes. All codes were allocated within the charts, for each subject. Where appropriate memos were added indicating significant questions or emerging themes.

Mapping and Interpretation

In research group meetings, emerging themes in relation to the developing thematic framework were discussed for each of the three main domains. The considerations brought to bear on the data during the mapping and interpretation phase were noted for each subject and are available from the principal researcher (AR). Provisional analysis summaries were compiled for each subject and validated through respondent validation (Lincoln & Guba, 1985; Creswell, 2003), in which respondents reviewed reports and provided feedback on the accuracy of

interpretations. Such feedback was not taken to provide final validation of the interpretation but was added to the totality of the data (Silverman 2000) and fed back into the process of framework development. Once validated, these were applied to the thematic framework, meaning it altered sequentially to a greater or lesser degree for each subject. This development is available from the principal researcher (AR). This provides a transparent description of the process of development from the initial thematic framework to the case-based framework containing dimensions and typologies. Subsequently a final overall reciprocal comparison between framework and data oriented to saturation was performed by AR and JL, and discussed in the research group.

2.5 Ensuring Rigor

The following strategies were employed in this study: triangulation, thick description, constant comparison, theoretical sampling, deviant case analysis, audit trail, and respondent validation. *Triangulation* involves the use of several different data sources, methodological approaches, multiple analysts, and the consideration of diverse theories to explain findings in order to reduce systematic bias in the data (Patton 1990). In this study, the data sources were the intake transcripts and the written records of these intakes, the MAQ, and the transcripts of the structured interview. Though coding was primarily performed by the primary researcher, members of the research group participated in independent coding of a number of participants and the results hereof were discussed with regard to the emergent themes and the developing thematic frameworks. *Thick description* (Abma and Stake 2001, Ponterotto 2006) refers to in-depth description of characteristics of a case (e.g. a particular psychiatrist's clinical practice) in order to provide the reader with an impression of the context, and to reduce the chance of the researcher taking individual comments in the interview or fragments from treatment sessions out of context to suit his purposes. Examples of thick description are provided in the descriptions of the results, and through extensive citations of interview fragments. *Constant comparison* involves testing provisional hypotheses by attempting to find new cases (Silverman 2000). In this study this is mostly present at the charting, mapping and interpretation stages. Theoretical sampling (ibid.) was the background for selecting three professional domains (academic, private, and institutional) within the sample of psychiatrists, and for selecting a subgroup of four psychiatrists from one institution for study. An *audit trail* (ibid.) is a record of decision making (either of the primary investigator or of the research team), of changing ideas with respect to emerging themes and the developing framework, of correspondence within the research team and with other relevant actors, and of summaries of researcher understanding of the project

at different points. This is provided by way of an extensive report for each subject of the process from coding, charting, mapping and interpretation, which is connected sequentially with explicit development of the thematic framework. *Deviant case analysis* involves searching for and discussing elements of the data that do not support or appear to contradict patterns or explanations that are emerging from data analysis. An example of this was the observation of a third style of interviewing in the intake besides the descriptive and narrative modes, which was discussed in the research group and related to other data sources in the study, leading to describing it as a separate mode of interviewing (see Chapter 2). Finally, *respondent validation* (Morse 1994) involves the testing of data, analytic categories, interpretations and conclusions with members of those groups from whom the data were originally obtained. This can be done both formally and informally as opportunities for member checks may arise during the normal course of observation and conversation. Respondent validation (also known as member checks, Lincoln & Guba, 1985) is viewed as a technique for establishing the validity of an account. In this study, member checks were performed at two points: during the structured interview, when interpretations based on the coding of the intake were presented, and in the final stage in which the final personal report was sent to all participants requesting corrections and comments.